Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VA Montana HCS (VAM&ROC Ft. Harrison - 436 and VA Eastern Montana HCS - 436A4), Miles City, MT

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 247

2. Estimated Number of Veterans who are Chronically Homeless: 96

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 247 (estimated number of homeless veterans in service area) **x chronically homeless rate (39 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	49	0
Transitional Housing Beds	45	17
Permanent Housing Beds	38	70

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Include VA families.
Treatment for substance abuse	Need a long-term treatment program with medical detoxification and follow-up
Other	Integrated networking program for services on a 24/7 availability with hotline and website used by veterans to get services.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **37** **Non-VA staff Participants: 68.8%**
Homeless/Formerly Homeless: **35.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.30	.0%	3.47
Food	3.81	11.0%	3.80
Clothing	3.52	7.0%	3.61
Emergency (immediate) shelter	3.58	21.0%	3.33
Halfway house or transitional living facility	3.19	29.0%	3.07
Long-term, permanent housing	2.27	32.0%	2.49
Detoxification from substances	3.26	14.0%	3.41
Treatment for substance abuse	3.50	18.0%	3.55
Services for emotional or psychiatric problems	3.5	14.0%	3.46
Treatment for dual diagnosis	3.2	11.0%	3.30
Family counseling	3.27	.0%	2.99
Medical services	3.64	4.0%	3.78
Women's health care	3.10	7.0%	3.23
Help with medication	3.44	.0%	3.46
Drop-in center or day program	2.45	.0%	2.98
AIDS/HIV testing/counseling	2.87	.0%	3.51
TB testing	3.39	.0%	3.71
TB treatment	3.40	.0%	3.57
Hepatitis C testing	3.31	.0%	3.63
Dental care	2.74	11.0%	2.59
Eye care	2.85	4.0%	2.88
Glasses	2.91	4.0%	2.88
VA disability/pension	3.06	21.0%	3.40
Welfare payments	2.83	.0%	3.03
SSI/SSD process	2.87	.0%	3.10
Guardianship (financial)	2.55	.0%	2.85
Help managing money	2.35	.0%	2.87
Job training	2.64	14.0%	3.02
Help with finding a job or getting employment	2.94	11.0%	3.14
Help getting needed documents or identification	3.22	.0%	3.28
Help with transportation	3.71	18.0%	3.02
Education	2.77	4.0%	3.00
Child care	2.20	.0%	2.45
Legal assistance	2.42	14.0%	2.71
Discharge upgrade	2.73	4.0%	3.00
Spiritual	3.35	18.0%	3.36
Re-entry services for incarcerated veterans	3.06	11.0%	2.72
Elder Healthcare	3.43	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.57
Co-location of Services - Services from the VA and your agency provided in one location.	2.14
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.19
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.05
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.42
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.32
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.89
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.63
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.72
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.26

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.68
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.19

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VA Southern Colorado HCS, (Colorado Springs-567)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 350

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 350 (estimated number of homeless veterans in service area) **x chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	268	40
Transitional Housing Beds	15	20
Permanent Housing Beds	14	20

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Dental care	Coordinate dental care for homeless veterans through VA Dental Clinic.
Long-term, permanent housing	Increase HUD Shelter Plus Care vouchers.
Immediate shelter	Expand Crawford House.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **38** **Non-VA staff Participants: 96.9%**
Homeless/Formerly Homeless: **31.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.61	3.0%	3.47
Food	3.56	11.0%	3.80
Clothing	3.40	11.0%	3.61
Emergency (immediate) shelter	2.91	39.0%	3.33
Halfway house or transitional living facility	2.61	8.0%	3.07
Long-term, permanent housing	1.89	62.0%	2.49
Detoxification from substances	3.14	3.0%	3.41
Treatment for substance abuse	3.06	19.0%	3.55
Services for emotional or psychiatric problems	3.1	14.0%	3.46
Treatment for dual diagnosis	2.8	.0%	3.30
Family counseling	2.56	.0%	2.99
Medical services	3.17	16.0%	3.78
Women's health care	2.53	3.0%	3.23
Help with medication	2.91	3.0%	3.46
Drop-in center or day program	2.49	.0%	2.98
AIDS/HIV testing/counseling	2.83	5.0%	3.51
TB testing	3.34	.0%	3.71
TB treatment	3.03	.0%	3.57
Hepatitis C testing	2.94	3.0%	3.63
Dental care	2.09	41.0%	2.59
Eye care	2.57	.0%	2.88
Glasses	2.59	3.0%	2.88
VA disability/pension	2.68	3.0%	3.40
Welfare payments	2.63	.0%	3.03
SSI/SSD process	2.70	.0%	3.10
Guardianship (financial)	2.79	.0%	2.85
Help managing money	2.68	5.0%	2.87
Job training	2.47	8.0%	3.02
Help with finding a job or getting employment	2.95	24.0%	3.14
Help getting needed documents or identification	2.89	.0%	3.28
Help with transportation	2.70	5.0%	3.02
Education	2.74	.0%	3.00
Child care	2.27	.0%	2.45
Legal assistance	2.26	11.0%	2.71
Discharge upgrade	2.69	.0%	3.00
Spiritual	2.75	.0%	3.36
Re-entry services for incarcerated veterans	2.35	5.0%	2.72
Elder Healthcare	2.53	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.29
Co-location of Services - Services from the VA and your agency provided in one location.	1.48
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.52
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.60
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.40
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.47
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.26
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.79
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.71
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.42
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.17
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.50

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.38
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	2.72

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VAM&ROC Cheyenne, WY - 442

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 76

2. Estimated Number of Veterans who are Chronically Homeless: 35

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 76 (estimated number of homeless veterans in service area) **x chronically homeless rate (46 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	0
Transitional Housing Beds	75	10
Permanent Housing Beds	20	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 1

3. CHALENG Point of Contact Action Plan for FY 2005

Dental care	Homeless healthcare clinics and shelters are searching for funds to increase dental care.
Long-term, permanent housing	Several new organizations have started the work of increasing affordable permanent housing in Wyoming. One new trust fund and one cooperative are working on this.
Services for emotional or psychiatric problems	Increasing mental health services to very rural parts of Wyoming is very challenging. CBOC mental health enhancement funding is a good start. Wyoming state surplus may allow enhancement to local mental health centers.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **38** **Non-VA staff Participants: 55.3%**
Homeless/Formerly Homeless: **2.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.44	9.0%	3.47
Food	3.69	9.0%	3.80
Clothing	3.83	3.0%	3.61
Emergency (immediate) shelter	3.58	18.0%	3.33
Halfway house or transitional living facility	2.80	24.0%	3.07
Long-term, permanent housing	2.40	27.0%	2.49
Detoxification from substances	3.47	16.0%	3.41
Treatment for substance abuse	3.46	19.0%	3.55
Services for emotional or psychiatric problems	3.4	25.0%	3.46
Treatment for dual diagnosis	3.3	3.0%	3.30
Family counseling	3.23	13.0%	2.99
Medical services	3.66	3.0%	3.78
Women's health care	3.38	9.0%	3.23
Help with medication	3.40	3.0%	3.46
Drop-in center or day program	2.71	6.0%	2.98
AIDS/HIV testing/counseling	3.34	.0%	3.51
TB testing	3.51	.0%	3.71
TB treatment	3.26	.0%	3.57
Hepatitis C testing	3.51	.0%	3.63
Dental care	2.69	39.0%	2.59
Eye care	2.79	3.0%	2.88
Glasses	2.91	3.0%	2.88
VA disability/pension	3.57	9.0%	3.40
Welfare payments	3.17	.0%	3.03
SSI/SSD process	3.21	.0%	3.10
Guardianship (financial)	2.80	.0%	2.85
Help managing money	2.86	6.0%	2.87
Job training	3.00	13.0%	3.02
Help with finding a job or getting employment	3.20	9.0%	3.14
Help getting needed documents or identification	3.26	3.0%	3.28
Help with transportation	2.91	6.0%	3.02
Education	2.89	9.0%	3.00
Child care	2.49	3.0%	2.45
Legal assistance	2.49	3.0%	2.71
Discharge upgrade	3.09	.0%	3.00
Spiritual	3.74	.0%	3.36
Re-entry services for incarcerated veterans	2.88	3.0%	2.72
Elder Healthcare	3.26	13.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.95
Co-location of Services - Services from the VA and your agency provided in one location.	1.50
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.50
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.50
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.30
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.42
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.50
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.65
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.60
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.45
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.42
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.37

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.35
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.30

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VA Eastern Colorado HCS (VAMC Denver - 554)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 3500

2. Estimated Number of Veterans who are Chronically Homeless: 1260

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 3500 (estimated number of homeless veterans in service area) **x chronically homeless rate (36 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	749	200
Transitional Housing Beds	657	240
Permanent Housing Beds	148	1000

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 8

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Encourage housing agencies to prioritize Shelter and care projects that serve homeless veterans in Metro Denver, and Colorado Springs and Pueblo.
Dental care	Continue to work with VA leadership to implement VHA Directive 2002-080 to provide dental care for homeless veterans in VA residential programs.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **33** **Non-VA staff Participants: 77.4%**
Homeless/Formerly Homeless: **27.3%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.57	4.0%	3.47
Food	3.81	8.0%	3.80
Clothing	3.84	.0%	3.61
Emergency (immediate) shelter	3.23	20.0%	3.33
Halfway house or transitional living facility	2.74	36.0%	3.07
Long-term, permanent housing	1.70	40.0%	2.49
Detoxification from substances	3.26	8.0%	3.41
Treatment for substance abuse	3.21	.0%	3.55
Services for emotional or psychiatric problems	3.4	8.0%	3.46
Treatment for dual diagnosis	3.2	20.0%	3.30
Family counseling	2.91	4.0%	2.99
Medical services	3.45	8.0%	3.78
Women's health care	2.79	.0%	3.23
Help with medication	3.28	.0%	3.46
Drop-in center or day program	3.00	.0%	2.98
AIDS/HIV testing/counseling	3.55	.0%	3.51
TB testing	3.90	.0%	3.71
TB treatment	3.72	.0%	3.57
Hepatitis C testing	3.74	.0%	3.63
Dental care	2.13	36.0%	2.59
Eye care	2.78	8.0%	2.88
Glasses	2.74	16.0%	2.88
VA disability/pension	3.09	8.0%	3.40
Welfare payments	2.61	.0%	3.03
SSI/SSD process	2.63	12.0%	3.10
Guardianship (financial)	2.35	.0%	2.85
Help managing money	2.55	.0%	2.87
Job training	2.71	12.0%	3.02
Help with finding a job or getting employment	3.00	16.0%	3.14
Help getting needed documents or identification	3.19	12.0%	3.28
Help with transportation	2.83	4.0%	3.02
Education	2.81	8.0%	3.00
Child care	2.10	4.0%	2.45
Legal assistance	2.37	8.0%	2.71
Discharge upgrade	2.77	.0%	3.00
Spiritual	3.07	.0%	3.36
Re-entry services for incarcerated veterans	2.40	.0%	2.72
Elder Healthcare	2.27	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.09
Co-location of Services - Services from the VA and your agency provided in one location.	2.09
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.41
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.59
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.17
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.17
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.32
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.52
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.32
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.91
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.09
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.36

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.38
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.46

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Grand Junction, CO - 575

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 45

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 45 (estimated number of homeless veterans in service area) **x** **chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	75	0
Transitional Housing Beds	8	0
Permanent Housing Beds	0	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Catholic Outreach is moving forward with grant applications for permanent supportive housing focusing on use of efficiency apartments.
Transportation	Continue to foster relationships with Mesa County Workforce Center and Grand Valley Transit to ensure eligible veterans receive transportation assistance as appropriate.
Treatment for substance abuse	Increase knowledge of resources available through VA for eligible veterans. Many community providers were unaware the VA had outpatient substance abuse treatment.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **4** **Non-VA staff Participants: 25.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.25	.0%	3.47
Food	3.75	.0%	3.80
Clothing	3.50	.0%	3.61
Emergency (immediate) shelter	2.75	.0%	3.33
Halfway house or transitional living facility	2.50	50.0%	3.07
Long-term, permanent housing	1.75	75.0%	2.49
Detoxification from substances	2.75	.0%	3.41
Treatment for substance abuse	2.50	50.0%	3.55
Services for emotional or psychiatric problems	2.5	.0%	3.46
Treatment for dual diagnosis	2.5	25.0%	3.30
Family counseling	3.00	25.0%	2.99
Medical services	3.00	.0%	3.78
Women's health care	3.25	.0%	3.23
Help with medication	2.25	.0%	3.46
Drop-in center or day program	2.75	.0%	2.98
AIDS/HIV testing/counseling	3.50	.0%	3.51
TB testing	3.50	.0%	3.71
TB treatment	2.75	.0%	3.57
Hepatitis C testing	3.50	.0%	3.63
Dental care	2.25	25.0%	2.59
Eye care	2.00	.0%	2.88
Glasses	2.00	.0%	2.88
VA disability/pension	3.25	.0%	3.40
Welfare payments	2.75	.0%	3.03
SSI/SSD process	2.33	.0%	3.10
Guardianship (financial)	2.33	.0%	2.85
Help managing money	1.75	25.0%	2.87
Job training	3.50	.0%	3.02
Help with finding a job or getting employment	3.50	.0%	3.14
Help getting needed documents or identification	3.00	.0%	3.28
Help with transportation	3.25	25.0%	3.02
Education	2.25	.0%	3.00
Child care	2.25	.0%	2.45
Legal assistance	2.75	.0%	2.71
Discharge upgrade	3.25	.0%	3.00
Spiritual	4.00	.0%	3.36
Re-entry services for incarcerated veterans	2.50	.0%	2.72
Elder Healthcare	2.50	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.00
Co-location of Services - Services from the VA and your agency provided in one location.	4.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	3.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	3.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	3.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	3.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	3.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	3.00

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.00
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.00

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Salt Lake City, UT - 660

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 585

2. Estimated Number of Veterans who are Chronically Homeless: 152

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 585 (estimated number of homeless veterans in service area) **x chronically homeless rate (26 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1054	40
Transitional Housing Beds	476	108
Permanent Housing Beds	511	140

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 20

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Salt Lake City Housing Authority, Crusade for the Homeless, and Housing Authority for the County of Salt Lake formed the Housing Assistance Management Enterprise. This coalition will build 5 100-unit permanent housing complexes with supportive services.
Help finding a job or getting employment	Collaborate with current VA Grant and Per Diem providers to explore ways to work closer with VA Vocational Rehabilitation program and see if Department of Labor grants can be utilized for funding employment counselors.
Transitional living facility or halfway house	VA homeless program will work with State Department of Corrections and Catholic Community Services to collaborate on separate capital grant applications of transitional housing. This housing will target (1) incarcerated veterans and (2) paroled veterans.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **35 Non-VA staff Participants: 61.3%**
Homeless/Formerly Homeless: **25.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.59	4.0%	3.47
Food	3.94	4.0%	3.80
Clothing	3.88	4.0%	3.61
Emergency (immediate) shelter	3.23	18.0%	3.33
Halfway house or transitional living facility	3.11	14.0%	3.07
Long-term, permanent housing	2.31	67.0%	2.49
Detoxification from substances	3.57	4.0%	3.41
Treatment for substance abuse	3.63	11.0%	3.55
Services for emotional or psychiatric problems	3.3	11.0%	3.46
Treatment for dual diagnosis	3.1	14.0%	3.30
Family counseling	2.78	11.0%	2.99
Medical services	3.77	14.0%	3.78
Women's health care	3.00	.0%	3.23
Help with medication	3.55	.0%	3.46
Drop-in center or day program	2.97	7.0%	2.98
AIDS/HIV testing/counseling	3.57	.0%	3.51
TB testing	4.30	.0%	3.71
TB treatment	4.13	.0%	3.57
Hepatitis C testing	4.03	4.0%	3.63
Dental care	3.00	.0%	2.59
Eye care	2.63	4.0%	2.88
Glasses	2.58	7.0%	2.88
VA disability/pension	3.58	14.0%	3.40
Welfare payments	2.97	.0%	3.03
SSI/SSD process	3.03	11.0%	3.10
Guardianship (financial)	3.03	.0%	2.85
Help managing money	3.09	7.0%	2.87
Job training	3.19	18.0%	3.02
Help with finding a job or getting employment	3.10	21.0%	3.14
Help getting needed documents or identification	3.58	.0%	3.28
Help with transportation	3.06	4.0%	3.02
Education	3.29	.0%	3.00
Child care	2.07	4.0%	2.45
Legal assistance	2.45	11.0%	2.71
Discharge upgrade	2.86	.0%	3.00
Spiritual	3.52	4.0%	3.36
Re-entry services for incarcerated veterans	2.42	11.0%	2.72
Elder Healthcare	3.19	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.06
Co-location of Services - Services from the VA and your agency provided in one location.	2.17
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.22
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.17
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.83
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.47
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.83
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.29
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.82
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.65
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.11

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.59
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.65

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Sheridan, WY - 666

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 35

2. Estimated Number of Veterans who are Chronically Homeless: 12

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 35 (estimated number of homeless veterans in service area) **x chronically homeless rate (34 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	19	0
Transitional Housing Beds	20	0
Permanent Housing Beds	88	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 8

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Work on transitional housing with the new Homeless Veterans Liaison/case manager -- more community agency contact and formal contracting with agencies.
Transportation	Volunteers of America will become more proactive in obtaining a van.
Help finding a job or getting employment	Will network with state of Wyoming Workforce service to provide job preparedness workshops for homeless veterans. Representatives will come to shelter and talk about registration process and continue to call shelter regarding availability of spot jobs.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **23** **Non-VA staff Participants: 52.2%**
Homeless/Formerly Homeless: **26.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	4.05	.0%	3.47
Food	4.64	5.0%	3.80
Clothing	4.23	5.0%	3.61
Emergency (immediate) shelter	4.68	.0%	3.33
Halfway house or transitional living facility	3.38	21.0%	3.07
Long-term, permanent housing	2.57	35.0%	2.49
Detoxification from substances	4.18	.0%	3.41
Treatment for substance abuse	4.64	5.0%	3.55
Services for emotional or psychiatric problems	4.6	11.0%	3.46
Treatment for dual diagnosis	4.3	11.0%	3.30
Family counseling	3.45	5.0%	2.99
Medical services	4.64	5.0%	3.78
Women's health care	4.05	.0%	3.23
Help with medication	4.48	.0%	3.46
Drop-in center or day program	2.75	26.0%	2.98
AIDS/HIV testing/counseling	3.90	.0%	3.51
TB testing	4.05	.0%	3.71
TB treatment	4.06	.0%	3.57
Hepatitis C testing	4.33	.0%	3.63
Dental care	3.41	16.0%	2.59
Eye care	3.36	5.0%	2.88
Glasses	3.23	11.0%	2.88
VA disability/pension	4.05	21.0%	3.40
Welfare payments	3.40	.0%	3.03
SSI/SSD process	3.71	11.0%	3.10
Guardianship (financial)	3.11	5.0%	2.85
Help managing money	3.37	5.0%	2.87
Job training	3.40	26.0%	3.02
Help with finding a job or getting employment	3.68	11.0%	3.14
Help getting needed documents or identification	3.81	5.0%	3.28
Help with transportation	3.18	40.0%	3.02
Education	3.21	5.0%	3.00
Child care	2.22	.0%	2.45
Legal assistance	3.20	5.0%	2.71
Discharge upgrade	3.21	.0%	3.00
Spiritual	4.00	.0%	3.36
Re-entry services for incarcerated veterans	2.80	.0%	2.72
Elder Healthcare	3.56	5.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.22
Co-location of Services - Services from the VA and your agency provided in one location.	2.90
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.22
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.13
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.80
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.29
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.86
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.50
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.29
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.14

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.58
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.90